Letters to the Editor

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A RELATIONSHIP BETWEEN FACTITIOUS DISORDER AND BORDERLINE PERSONALITY DISORDER

Dear Editor:

We describe a patient who presented with repeated episodes of hypoglycemia, confirmed by laboratory studies, which unfolded as the surreptitious use of insulin. Upon further evaluation, this patient was also noted to have a number of clinical features consistent with borderline personality disorder (BPD). Through this case report, we examine a possible relationship between factitious disorder and BPD.

Case report. Miss A was a 35-year-old White woman who initially presented to the internal medicine outpatient clinic with a history of multiple episodes of hypoglycemia. The patient stated that these episodes had been occurring almost daily and were characterized by tremulousness, lightheadedness, and diaphoresis, accompanied by full body jerks without the loss of consciousness. These episodes had previously resulted in multiple prolonged hospitalizations, including brief stays in the intensive care unit. The patient's past medical history included hypertension; multiple abdominal surgeries, including gastric bypass surgery with multiple revisions and treatment of adhesions; nondiabetic gastroparesis following gastrojejunal tube placement; pseudoseizures; depression; anxiety; and cocaine misuse. Importantly, the patient had no history of diabetes mellitus. At presentation, medications included tizanidine, promethazine, levetiracetam (despite no documented seizures), lansoprazole, oxycodone/acetaminophen, and clonazepam.

During the initial portion of the outpatient consultation, the patient was asymptomatic. However, after the primary care provider departed from the examination room and returned, the patient began to evidence slowed mentation, severe diaphoresis, and tremulousness. A serum glucose was 31mg/dL. The patient was immediately administered chewable glucose tablets and orange juice, which resulted in the normalization of her serum glucose level. However, 10 minutes later, a follow-up serum glucose level was 50mg/dL. The patient was then admitted to a nearby hospital, was placed on intravenous 10-percent dextrose in water, and symptomatically improved.

While in the hospital, the patient's admission physical examination and laboratory studies were normal. However, when the treatment team revisited the patient, she became progressively lethargic, diaphoretic, and tremulous. Her serum glucose level was 40mg/dL. In the wake of the patient's unusual history (i.e., pseudoseizures, multiple hospitalizations), the surreptitious use of insulin or oral hypoglycemic agents was considered. A C-peptide level was ordered to evaluate for possible factitious disorder. In the meantime, the patient was transferred to the intensive care unit and given intravenous 10-percent dextrose in water.

In the intensive care unit, to eliminate the possibility of the surreptitious administration of a hypoglycemic agent, the patient was asked by the treatment team if she would reveal the contents of her purse. In response, the patient became explosive and angry. Because the patient continued to pose a potential threat to herself due to the suspected self-administration of hypoglycemics, security was notified, searched her belongings, and uncovered two insulin pens. When confronted with the evidence, the patient denied knowing about the insulin pens. However, after the pens were confiscated, the patient's serum glucose levels completely normalized. She was discharged from the hospital after a psychiatric evaluation, which confirmed the diagnosis of factitious disorder. As expected, the patient's C-peptide levels were undetectable, which is consistent with the surreptitious use of injectable insulin. It was later determined that the patient had obtained the insulin pens from her father, who had diabetes.

In follow-up, the patient was screened for BPD. During the interview, the patient acknowledged the following DSM-5[1] criteria: 1) intense fears of abandonment; 2) unstable interpersonal relationships (i.e., "My relationships have been very chaotic," which she attributed to intense fears of abandonment); 3) impulsivity (e.g., history of obesity and cocaine use); 4) recurrent suicidal thoughts and self-destructive behavior (e.g., chronic threats of suicide, surreptitious injection of insulin, introduction of fecal material into intravenous fluids, pseudoseizures); 5) affective instability (e.g., chronic mood difficulties characterized by longstanding anxiety and depression as well as irritability); 6) chronic feelings of emptiness (e.g., the patient stated, "Since age 13, I have felt empty, sad, and anxious due to my family situation"); 7) inappropriate intense anger (i.e.,

rage reactions); and 8) transient dissociative symptoms as well as fleeting periods of derealization and evanescent visual hallucinations. The only DSM-5 criterion for BPD that was not endorsed by the patient was identity disturbance. All symptoms were in the context of a superficially intact social veneer.

Discussion: According to the DSM-IV-TR,[2] factitious disorder is characterized by three core criteria: 1) the intentional production or feigning of physical or psychological signs or symptoms by an individual; 2) symptoms are motivated by the need to assume the sick role; and 3) and there is a lack of external incentives for the symptoms (e.g., financial gain)—all of which this patient fulfilled.

There are few data on the relationship between factitious disorder and BPD. However, there are several case reports in the literature that affirm an association between BPD and the factitious symptoms of hemiplegia,[3] blindness,[4] and rape.[5] Factitious disorder by proxy has also been associated with BPD.[6] In addition to case reports, Goldstein reported that 11/19 (58%) patients with factitious disorder met the criteria for BPD;[7] based upon these findings, he suggested a new classification of factitious disorder that would account for the presence of BPD. Rothenhausler and Kapfhammer stated that the majority of patients with factitious disorder suffer from Cluster B personality disorders, particularly BPD.[8] Bouden and colleagues indicated that in factitious disorder by proxy, the perpetrator of the surreptitious symptoms is most likely suffering from BPD.[9] Finally, the association between factitious disorder and BPD has been previously suggested and discussed by Sansone and Sansone.[10]

The elemental psychological association between these two DSM disorders seems to be that the self-destructive behavior observed in BPD may be actualized through a self-harming pattern of contrived or simulated symptoms—which may be experienced by the patient through surreptitious medications, procedures, and/or surgeries. This potential relationship underscores the need to evaluate every individual who presents with factitious disorder for BPD. The confirmation of comorbid BPD will hopefully facilitate treatment for this Cluster B disorder and there are a number of available evidence-based treatments, such as dialectical behavior therapy, mentalization-based therapy, schema-focused therapy, and transference-focused therapy.[11]

Conclusions: In a number of cases, BPD and factitious disorder appear to demonstrate a meaningful clinical relationship. Because of this potential relationship, it is important to evaluate patients with factitious disorder for BPD, and when present, to facilitate the patient's referral to a mental health professional for the treatment of BPD. Clearly, the intersection of these two disorders is an area worthy of additional research.

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